

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-013609

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2759

STATE FILE NUMBER

FILED MAR 20 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR
TOWN

St. Louis

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

admission)

c. CITY
OR
TOWN

St. Louis 13

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR
INSTITUTION

De Paul Hospital

Inside Limits

Yes ☐ No ☐d. STREET
ADDRESS

(If outside, give location)

5027 Northland

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First

Thomas

Middle

Monaghan

Last

4. DATE
OF
DEATH

Month

Day

Year

3 - 7 - 63

5. SEX

m

6. COLOR OR RACE

w

7. Married ☐ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

10 - 26 - 86

9. AGE (last birthday)

86

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY

**

11. BIRTHPLACE (City and state or country)

St. Louis Mo.

12. CITIZEN OF WHAT COUNTRY

U.S. A.

13a. FATHER'S NAME

Patrick J. Monaghan

13b. MOTHER'S MAIDEN NAME

(Unknown)

14. NAME OF HUSBAND OR WIFE

Never Married

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Ed. J. Tackaberry, 8635 Oxford Lane.

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Heart failure

Fracture of hip

904.0-21

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

1 week

1 week

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

Fell at home

20c. TIME OF INJURY

Hour: a.m. p.m.

Feb. 28 1963

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

20f. CITY, TOWN, OR LOCATION

St. Louis

COUNTY

STATE

Mo.

21. I attended the deceased from _____ to _____ and last saw her alive on _____

Death occurred at 9:40 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

De Paul Hosp.

22c. DATE SIGNED

3/8/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

Mar. 11 1963

23c. NAME OF CEMETERY OR CREMATORY

Mt. Hope Cemetery

23d. LOCATION (City, town, or county)

Perryville, Missouri

(State)

24. FUNERAL DIRECTOR

ADDRESS

JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.

25. DATE RECD. BY LOCAL REG.

MAR 9 1963

26. REGISTRAR'S SIGNATURE

Ward Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

1

2 206

3

4 0

5 0

6

7 0

8 2

9

10

11 000

12 59-0

13

59

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

J. M. Rister

Licensed Embalmer No.

3980

P. O. Address

St. Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.